

Medical Malpractice Claims Study



2001

Casualty Actuarial Section

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Introduction

Section 155.19 of the Illinois Insurance Code requires insurance companies to report medical liability claims or suits occurring in Illinois to the Department of Insurance. This section also requires the Director of Insurance to release, from time to time, statistical reports based on such data and information. This reporting statute was created to assist the Department of Insurance in monitoring medical malpractice insurance, which is a long-tailed and volatile line of insurance business.

The following study is based on reported medical malpractice claims closed in Illinois from January 1, 1980 through December 31, 1999. The form used for reporting medical malpractice closed claims information, the NAIC Medical Professional Liability Insurance Uniform Claims Report, is in Appendix A. This study gives a factual, statistical analysis of the data reported to the Department. It tries to encompass all important areas of analysis, including “Indemnity Paid” and “Amounts Paid to Defense Counsel.” “Indemnity Paid” is the total amount of dollars of loss settlement paid by the insurance company. “Amount Paid to Defense Counsel” refers just to defense attorneys’ fees paid by the insurance company.

Each closed claim covers one defendant (doctor). If a claimant sued more than one doctor associated with the injury, then each of these associated claims is considered a separate claim in the study. All closed claims for physicians and surgeons are included; however, hospitals, clinics, and other professionals are not included in this study. Since a large percentage of hospitals are self insured, and the Department only receives claims reports from admitted insurance writers, our data is not complete.

In the first section, the data is analyzed on a yearly basis, revealing the trends apparent in comparisons. For the remainder of the report, the data is consolidated into four groupings by year of closure date: 1980–1984, 1985–1989, 1990–1994, and 1995–1999. For the purposes of this report, these groupings allow comparisons of the data to be manageable.

Please note that the data used in the previous medical malpractice closed claims study and that used in the 2001 Medical Malpractice Closed Claims Study does not completely reconcile. The discrepancies are due to changes in the review process as reports are filed. The data in the 2001 study is more complete and, thus, more accurate.

This study is intended to be a complete statistical analysis of medical professional liability claims data received by the Illinois Department of Insurance. If there are any questions or comments on the content of the report, or requests for additional copies of the report, please contact Yoko I. Chism, Actuarial Assistant, at the Illinois Department of Insurance.

1. Yearly Comparison

Indemnity Paid

In this section the data is shown on a yearly basis, allowing year-to-year comparisons to be made and trends to be revealed.

Table 1–1 shows the closed claims data by the year the claim was closed. It lists the total number of closed claims, the number of claims closed with payment, the number of claims closed without payment, the average indemnity of claims closed with payment and the total indemnity paid. The total indemnity paid and average indemnity paid numbers only reflect the payment made by the insurance company representing the doctor. Any payments made by the doctor or any other party are not a part of this study.

As the table shows, the total number of closed claims for all years combined was 48,096; of that total 11,527 were closed with an indemnity payment. The percent of claims closed with payment was 24.0%. Total indemnity paid on all claims was \$3.56 billion.

The total number of closed claims increased annually from 1980 to 1987. In the next three years, the number of closed claims dropped more than 28% from 3,225 to 2,308. In 1991 and 1992 the claims increased again to more than 3,200, but since 1993 the numbers have remained steady.

Graph 1–1 displays the total number of closed claims. Each bar is broken into two segments to illustrate the portion of claims that closed with payment compared to the portion that closed without payment. Beginning around 1993, the number of claims closed with payment and claims closed without payment remained steady.

Graph 1–2 shows that the total indemnity paid has increased dramatically up to the early 1990s. In the past several years, however, the total indemnity paid for medical malpractice insurance claims appeared to be fairly stable.

Graph 1–3 displays average indemnity paid by date the claim closed. This graph only includes claims that closed with an indemnity payment. It shows how average payments have increased over the years. The largest increase in the amount of average payment was between 1990 and 1991, which was about a \$122,845 increase, or an increase of 53.6%. The largest percentage increase, 148.8%, was between 1981 and 1982 when average indemnities increased from \$58,601 to \$145,804.

Defense Costs Paid

This part of the yearly comparison data is devoted to the analysis of defense costs paid for closed claims. Plaintiff attorney fees are charged by the attorney representing an injured person. According to the Code of Civil Procedure 753 ILCS 5/2–1114, contingent fees for plaintiff attorneys in medical malpractice actions shall not exceed the following amounts:

- 33 1/3% of the first \$150,000 of the sum recovered;
- 25% of the next \$850,000 of the sum recovered; and
- 20% of any amount recovered over \$1,000,000 of the sum recovered.

For example, if the amount of indemnity paid equals \$500,000, then contingent attorney fees can be as high as \$137,500. This example does not consider plaintiff attorney fees that are charged on an hourly basis. The actual amounts paid to plaintiff attorneys are not required to be filed with the Illinois Department of Insurance; therefore, further analysis is not available.

Tables 1–2, Graph 1–4 and Graph 1–5 illustrate the amounts paid to defense counsel by the insurance company. Tables 1–2 show the total number of closed claims by year. The next three columns represent the number of claims closed with payment to defense counsel. The first of these three columns shows the number of claims without indemnity payment but with payment to defense counsel; the second shows the number of claims with an indemnity payment and payment to defense counsel; and the third shows the total number of closed claims with payment to defense counsel.

The percent of claims with payment to defense counsel is calculated by taking the total number of claims with payment to defense counsel divided by the total number of closed claims. This column shows that a higher percent of claims had payment to defense counsel in the mid to late 1980s and the mid to late 1990s than the overall average.

The next half of Table 1–2 refers to average payment to defense counsel on claims without indemnity payment, average payment to defense counsel on claims closed with indemnity payment, and total payment to defense counsel. As can be seen, over \$496 million was spent on defense costs of medical malpractice in the last twenty years. Of the \$496 million, \$383 million (77%) was spent in the last ten years. Furthermore, \$264 million, which was over 50%, was spent in the last six years. As previously stated, these amounts only represent the amounts paid by the insurance company.

Graph 1–4 displays the total number of closed claims with payment to defense counsel. The number of claims with indemnity payment and payment to defense counsel versus the number of claims without indemnity payment but with payment to defense counsel. The largest increase in the total number of closed claims with payment to defense counsel occurred between 1986 and 1987, which was 496 claims. The largest decrease was between 1988 and 1989, which was 792 claims.

Graph 1–5 shows the average payment to defense counsel, broken down into three bars. The bars represent average payment to defense counsel on claims without indemnity payment, average payment to defense counsel on claims closed with indemnity payment, and overall average payment to defense counsel of all claims with a defense counsel payment.

In this graph, it is apparent that average payment to defense counsel on claims closed with an indemnity payment was much greater than average payment to defense counsel on claims without an indemnity payment. It also illustrates that the recent average payment to defense counsel on medical malpractice claims in the 1990s was much higher than in the 1980s.

2. Indemnity Paid per Claim

For the remainder of this report, the data is analyzed in four groupings, each consisting of five years of data: 1980 through 1984, 1985 through 1989, 1990 through 1994, and 1995 through 1999. These groupings make the data more manageable and allow for comparisons.

Graph 2–1 illustrates the historical increase of average indemnity paid. Between 1980–1984 and 1985–1989 the increase was 61%; between 1985–1989 and 1990–1994 the increase was 71%; and between 1990–1994 and 1995–1999 the increase was 38%.

Tables 2–1 represent the average indemnity paid per claim. The indemnity paid column separates the data into eleven categories at \$100,000 intervals. The rest of the columns show the number of claims with payment relative to the corresponding category, the total indemnity paid, the average indemnity of paid claims, and the percent of total indemnity paid by category.

The majority of claims with payment were in the \$1–\$99,999 range. The data for that category is, therefore, separated even further later in this section. The \$1,000,000 and over category consistently showed the highest percent of total indemnity paid. Of the \$3.56 billion of indemnity paid over the last twenty years, this category accounted for 45.6%. However, it only accounted for 7.1% of the total number of closed claims with an indemnity payment. Total indemnity paid showed a 175.9% increase from 1980–1984 to 1985–1989, and an 80% increase from 1985–1989 to 1990–1994. A slight increase was shown from 1990–1994 to 1995–1999.

Graph 2–2 reflects the total number of claims by each indemnity paid category. Each five–year grouping is represented by a bar, which illustrates changes in the distribution.

Claims with Indemnity Paid less than \$100,000

For further analysis, the \$1–\$99,999 category is divided into subintervals of \$10,000. Tables 2–2 distribute the data according to these subintervals. Five thousand four hundred seventy-eight (5,478) claims, or 47.5% of the total 11,527 claims, were less than \$100,000; however, this category represented only 4.9% of the \$3.56 billion paid.

Tables 2–2 illustrate that the \$1–\$9,999 group consistently had the highest frequency of claims until the mid 1990s. Total indemnity paid was highest during 1985–1989 but began to trend downward over the next two groupings. Total indemnity decreased 43.2% from 1985–1989 to 1995–1999. The average indemnity paid on claims closed with indemnity payment under \$100,000 had gradually increased over the years. From 1980–1984 to 1985–1989 it increased by 23.7%, from 1985–1989 to 1990–1994 it increased 26.5%, and from 1990–1994 to 1995–1999 it increased 7.6%.

Graph 2–3 compares the number of closed claims with payment to the subintervals of the \$1–\$99,999 range. Each indemnity paid subcategory had a decreasing trend in recent years.

3. Amount Paid to Defense Counsel per Claim

The charts in this section look at the data with respect to the amount of indemnity paid on a claim. Tables 3–1 show, by category, the total number of closed claims in each interval, the number of claims with payment to defense counsel, the total paid to defense counsel, the average payment to defense counsel, and the percentage of total amount paid. Graph 3–1 illustrates a significant increase in the total amount paid to defense counsel.

Tables 3–1 illustrate how the amount of indemnity paid relates to the amount of defense costs paid. The total paid to defense counsel was consistently largest in the \$0 range, yet the average amount paid was the smallest from year to year. By comparing the total average payment to defense counsel in each grouping, it can also be seen that average payment to defense counsel was on the rise. From 1980–1984 to 1985–1989 it increased 73.4%; from 1985–1989 to 1990–1994 it increased 99.1%; and from 1990–1994 to 1995–1999 it increased 17.3%.

Graph 3–2 illustrates average payment to defense counsel by the indemnity paid categories. Each bar represents the data grouped by the year the claim was closed. This graph also shows a rise in defense costs over time.

4. Time Lapse from Report Date to Closure Date

For the next three sections of the report, the data is analyzed to determine how the lapse of time affected claims. Three important dates are associated with each claim: the injury date, which is the approximate date the injury occurred; the report date, which is the date the insurance company became aware of the claim; and the closure date, which is the date the insurance company considered the claim to be settled.

The charts in this section focus on the time lapse between the report date and the closure date. Claims data is based on the length of time between these two dates, with the intervals of six months in length for ten years.

Table 4–1 summarizes data for all years 1980–1999. Because medical malpractice insurance is a long-tailed line of business, it took an average of approximately 2.6 years, which was a little over 2 years and 7 months, to close claims after they were reported. Of the claims closed with an indemnity payment, only 38.1% were closed within two and a half years of the report date. On average, it took 3.5 years to close a claim with an indemnity payment.

Tables 4–2 on the following pages represent the time lapse between the report date and the closure date for each of the four data groups, which were determined by the year the claim closed. The tables show the total number of closed claims, as well as the number of claims with an indemnity payment. The paid ratio is the number of claims with payment divided by the total number of closed claims within each six-month interval. For example, 26.40% came from 146/553. This ratio shows the number of closed claims with an indemnity payment as a percent of total closed claims for each six-month interval.

The average paid ratio was 31.68% for 1980–1984, 23.90% for 1985–1989, 24.40% for 1990–1994, and 20.29% for 1995–1999. By observing each table, it is apparent that the paid ratios for claims lasting longer than two and a half years were higher than their corresponding averages.

These tables also represent total indemnity paid in each interval, percent of total indemnity paid, and average indemnity paid for claims. Graph 4–1 illustrates the average indemnity paid by age of the claim and shows that these distributions were not consistent. Each line represents the data by groupings according to the year the claim closed.

5. Time Lapse from Injury Date to Report Date

This section of the study focuses on the length of time between injury date and report date, and how the time lapse affects the closed claims data. Claims data is classified by the length of time between these two days. Intervals are six months in length for ten years.

Table 5–1 summarizes the data for the years 1980–1999. Approximately 75.5% of the closed claims had a time lapse of two and a half years or less between injury date and report date. About 79.9% of the claims closed with payment had less than a two and a half year time lapse. The average time lapse was 2.3 years for all closed claims and 2.2 years for closed claims with payment. These numbers are not surprising. Under the Statutes of Limitations law, all claims by adults need to be reported within two years of the date of injury or the date of discovery of the injury, but not to exceed four years from the date of injury. If an injured person is under the age of 18, the claim must be reported by the age of 22 or eight years after the discovery of the injury, whichever comes first.

Tables 5–2 represent the time lapse between injury date and report date using the four data groupings, categorized by the year the claim closed. The tables show the total number of claims closed, the number of claims with an indemnity payment and the paid ratios. The paid ratio column is calculated in the same manner, as explained in the previous section. The paid ratios did not seem to be affected by the length of time between injury date and report date.

Also represented in these tables are the total indemnity paid in each interval, the percentage of the total indemnity paid and the average indemnity paid of the claims with payment.

Graph 5–1 illustrates the average indemnity paid by the time lapse of the claim. Each line represents the data by group according to the year the claim closed. As with the graph for the time lapse between report date and closure date, it is apparent that these distributions were not consistent.

6. Time Lapse from Injury Date to Closure Date

In this section the time lapse from injury date to closure date is analyzed. In Table 6–1, Tables 6–2, and Graph 6–1, the data is divided into six–month intervals, up to ten years. This section encompasses the previous two sections by focusing on the entire length of claims, from injury date to report date to closure date.

Table 6–1 summarizes the claims data for the years 1980–1999. Most of the claims closed between 25 months and six years after the injury date. Those claims represented approximately 60.0% of the total closed claims. The average time lapse between injury date and the closure date for all closed claims was 4.7 years. The average time lapse was, however, 5.2 years on claims closed with an indemnity payment.

Tables 6–2 illustrate the time lapse between injury date and closure date using four data groupings, categorized by the year the claim closed. These tables include the same types of data as the two previous sections. The paid ratio did not appear to fluctuate in any particular pattern. This finding is consistent with ones in the two previous sections on the paid ratio.

Also shown are the total indemnity paid at each interval, the percent of total indemnity paid and the average indemnity paid of the claims with payment. None of this data showed a consistent distribution from year to year.

Graph 6–1 represents the average indemnity paid by the length of time between injury date and closure date.

7. Indemnity Paid by Severity of Injury

The next two sections of the report relate the claimant's severity of injury to the amount of indemnity paid by the insurance company. On each closed claim received by the Illinois Department of Insurance, the severity of injury is coded. Examples of the codes are as follows:

- **Emotional**—fright, no physical damage;
- **Insignificant Temporary**—lacerations, contusions, minor scars, rash; no delay;
- **Minor Temporary**—infections, misset fracture, fall in hospital; recovery delay;
- **Major Temporary**—burns, surgical material left, drug side effect, brain damage; recovery delay;
- **Minor Permanent**—loss of fingers, loss or damage to organs; includes nondisabling injuries;
- **Significant Permanent**—deafness, loss of limbs, loss of eye, loss of one kidney or lung;
- **Major Permanent**—paraplegia, blindness, loss of two limbs, brain damage;
- **Grave Permanent**—quadriplegia, severe brain damage, lifelong care or fatal prognosis.

Tables 7-1 represent the number of claims with payment and the amount of indemnity paid by severity of injury. It is apparent that a substantial amount of the indemnity paid in each grouping was for claims with a severity of major permanent, grave permanent and death. These paid amounts were much higher than the paid amounts for the rest of the severities.

In the 1980-1984 grouping, the worst three severities combined accounted for 60% of the total indemnity paid, yet these three severities represented only 34.9% of the number of claims with an indemnity payment. In the other groupings, the percentage of total indemnity paid for these three severities was 71.6%, 73.9%, and 77.3% in the 1985-1989, 1990-1994, and 1995-1999 groupings respectively.

The grave permanent had the single highest average indemnity paid amount of all the severities for each grouping. In 1980-1984 the average for this severity was approximately \$464,699, which was 261% greater than the overall average payout of \$128,878. Similar percentages were also found in the other groupings. The average payout for grave permanent was \$736,763, \$863,541, and \$1,384,229 in the 1985-1989, 1990-1994, and 1995-1999 groupings respectively.

The average payout of \$1,384,229 for grave permanent in the 1995-1999 grouping was nearly 3 times the corresponding overall average indemnity paid of \$490,692 for the same time period. Grave permanent, however, had one of the lowest percent of claims with payment for all of the groupings.

Death claims consistently had the highest percentage of the number of claims with payment. In 1980–1984, the percent of claims with an indemnity payment for the death severity code was 23.0%. In 1985–1989 the percentage increased to 27.1%. In 1990–1994 it increased again to 31.7%, and in 1995–1999 it maintained a high percentage of 30.5%.

Graph 7–1 illustrates the average indemnity payment by severity of injury. Each line represents a grouping by the year of closure. The distributions appear to be fairly consistent, which is especially apparent by the grave permanent severity peak.

The final part of this section compares the claimant’s severity of injury to the amount of indemnity paid, while taking into consideration the age of the injured party. Tables 7–2 are separated into four sections for each grouping: infants (age 0 to 3), minors (age 4 to 17), adults (age 18 and older), and unknown.

In 1980–1984, the total indemnity paid was approximately \$247 million. Of that amount, \$55 million (22.2%) was for claims of infants, \$20 million (8.2%) was for claims of minors, and \$135 million (54.5%) was for claims of adults. One thousand nine hundred sixteen (1,916) claims were closed with an indemnity payment. Of those claims, 186 (9.7%) were for claims of infants, 124 (6.5%) were for claims of minors, and 1,311 (68.4%) were for adults.

In 1985–1989, the total indemnity paid was approximately \$681 million. Of that amount, \$194 million (28.5%) was for claims of infants, \$27 million (4.0%) was for claims of minors, and \$422 million (62.0%) was for claims of adults. The number of claims closed with an indemnity payment in this time period was 3,287. Of those, 457 (13.9%) were for claims of infants, 182 (5.5%) were for claims of minors, and 2,366 (72%) were for adults.

In 1990–1994, the total indemnity paid was \$1.228 billion. Of that amount, \$301 million (24.5%) was for claims of infants, \$78 million (6.4%) was for claims of minors, and \$827 million (67.3%) was for claims of adults. During this time period, 3,462 claims were closed with an indemnity payment. Of these claims, 552 (15.9%) were for infants, 196 (5.7%) were for minors, and 2,560 (74.0%) were for adults.

In 1995–1999, the total indemnity paid was approximately \$1.5 billion. Of that amount, \$392 million (27.9%), \$52 million (3.7%), and \$949 million (67.6%) were for claims of infants, minors, and adults, respectively. The total number of claims was 2,862. Of these claims, 460 (16.1%) were for infants, 142 (5.0%) were for minors, and 2,171 (75.9%) were for adults.

Overall, the amount of indemnity paid between 1980 and 1999 was more than \$3.56 billion. Infants’ claims over this time period totaled \$941 million, minors’ claims totaled \$177 million, and adults’ claims totaled \$2.3 billion. Over this same twenty-year period, 11,527 claims were closed with an indemnity payment. Of the amount, 1,655 (14.4%) were for infants, 644 (5.6%) were for minors, and 8,408 (72.9%) were for adults.

Graphs 7–2 illustrate average indemnity payment by severity of injury. Each line represents an age group of the injured party.

8. Defense Costs for Closed Claims with Indemnity Payment

This section analyzes the defense costs paid by the insurance company for closed claims with an indemnity payment. Tables 8–1 present data by severity of injury, showing the number of claims with an indemnity payment, and how many of those had a defense counsel payment. They also illustrate the amounts of defense costs paid for claims with an indemnity payment according to the severity of injury of the claim.

In 1980–1984, 1,916 claims were closed with an indemnity payment. Of these claims, 1,684 (87.9%) were also closed with defense counsel fees. During this time period a total of \$11.4 million was paid to defense counsel, giving an average defense cost of \$6,759 for each claim with an indemnity payment.

In 1985–1989, 3,287 claims were closed with an indemnity payment, and 3,010 (91.6%) of those claims also made a payment to defense counsel. The total payment to defense counsel on closed claims with an indemnity payment was approximately \$44 million, making the average payment to defense counsel on these claims \$14,597.

The total number of claims closed with an indemnity payment in 1990–1994 was 3,462. Of these claims, 3,173 (91.7%) made a payment to defense counsel. The total amount paid for defense counsel for claims with an indemnity payment was approximately \$85 million, making the average payment to defense counsel \$26,819.

In 1995–1999, 2,862 claims were closed with an indemnity payment. Of these claims, 2,607 (91.1%) paid defense counsel fees. During this time period, \$95.4 million was paid to defense counsel, giving an average defense cost of \$36,600 for claims closed with an indemnity payment.

Overall, defense costs appear to be on the rise. Average defense costs on claims with an indemnity payment rose 116% between 1980–1984 and 1985–1989, 84% between 1985–1989 and 1990–1994, and 36% between 1990–1994 and 1995–1999. Graph 8–1 illustrates this apparent trend.

Death claims have consistently reported the highest defense costs for claims with an indemnity payment. A total of \$70 million was spent over the last 20 years for death claim defense costs, which represented 29.7% of the total paid amount to defense counsel on claims with an indemnity payment over the same time period.

Graph 8–2 illustrates the average payment to defense counsel on claims closed with an indemnity payment by severity of injury. Although the graph may not appear to be consistent between groupings, overall defense costs on closed claims with an indemnity payment were increasing from one grouping to the next.

Defense Costs for Closed Claims without Indemnity Payment

It is also important to study the defense costs paid by the insurance company on claims that closed without an indemnity payment. The data is again sorted by severity of injury. Tables 8–2 show the numbers of claims closed without payment, the number of those claims with payment to defense counsel, and the total amount of those payments.

In 1980–1984, 4,132 claims were closed without an indemnity payment. Of those claims, 3,044 (73.7%) made a payment to defense counsel. The total defense cost on closed claims without payment was approximately \$10.6 million, with an average of \$3,490 per claim.

In 1985–1989, the total number of closed claims without payment totaled 10,465. Of those claims, 8,692 (83.1%) made a payment to the defense counsel, bringing the total paid for defense costs approximately \$50.5 million. The average payment to defense counsel was \$5,813.

In 1990–1994, 10,727 claims were closed without an indemnity payment. Of these claims, 8,011 (74.7%) made a payment to defense counsel. The total amount paid to defense counsel was nearly \$94.6 million, with an average of \$11,811 per claim.

In 1995–1999, the total number of closed claims without payment was 11,245. Of those claims, 9,139 (81.3%) made a payment to defense counsel. The total paid to defense counsel for claims without payment was almost \$126 million, giving an average payment to defense counsel of \$13,781.

The overall data again shows that defense costs are rising. Average defense costs increased by 66.6% from 1980–1984 to 1985–1989, 103% from 1985–1989 to 1990–1994, and 17% from 1990–1994 to 1995–1999. Graph 8–3 illustrates a similar trend as Graph 8–1.

Death claims have consistently been the severity with the highest payment to defense counsel for claims with no indemnity payment. In the past 20 years, \$83 million (29.5% of the total defense costs paid on claims with no indemnity payment) was spent on death claims without an indemnity payment.

Graph 8–4 displays the average payment to defense counsel on claims closed without an indemnity payment by the severity of injury. Overall defense costs on closed claims without an indemnity payment are steadily increasing over time. The same observation was made from Graph 8–2.

9. Indemnity Paid by Type of Practice

This section shows the data by the doctor's practice/specialty. The data in Table 9-1 is separated by closure date into the four groupings. Each grouping shows the number of claims with an indemnity payment and the corresponding total claims by physician's specialty. Definitions of practices/specialties are listed in Appendix B.

Table 9-1 lists the specialties in decreasing order of occurrence across all four groupings. Claims by doctors specializing in OB/GYN Surgery occurred most frequently, totaling 1,571 claims with an indemnity payment over the past twenty years. General Surgery had the second largest number of claims (1,209), and Family/General Practice Minor Surgery had the third largest number (1,025).

The specialties with the greatest percentage increase in the number of claims with an indemnity payment from 1980-1984 to 1995-1999 were Radiology Minor Surgery, Cardiac/Cardiovascular Surgery, OB/GYN Surgery, and Emergency Medicine. They increased 440.9%, 437.5%, 157.9%, and 144.4%, respectively. Graph 9-1 illustrates this trend. Table 9-1 and Graph 9-1 also show that in every category except emergency medicine and plastic surgery, there is a decrease in the number of claims with payment from 1990-1994 to 1995-1999.

Table 9-2 lists the average amount of indemnity paid by specialty in the four year groupings. It indicates that the average amount of indemnity paid is generally increasing in each specialty. Graph 9-2 also shows this trend. Claims by doctors specializing in OB/GYN Surgery have the highest total indemnity payment of \$681,038,965 over the past twenty years. General Surgery had the second highest total amount paid (\$305,664,141), and Family/General Practice Minor Surgery had the third highest total amount paid (\$291,641,705).

10. Time Lapse for Closed Claims by Severity of Injury

This section compares the average length, in months, of closed claims with an indemnity payment against those without an indemnity payment. The data here is analyzed by the severity of injury of the claim.

For each severity of injury category, Tables 10–1 display both the number of claims with an indemnity payment and the number of closed claims without an indemnity payment. The tables also show the average months from the injury date to the report date and the average months from the report date to the closure date. The sum of two columns equals the average months from the injury date to the closure date. Graph 10–1 illustrates the changes in the average length of claims closed with payment over the years by grouping.

When comparing claims closed with an indemnity payment and claims closed without an indemnity payment, it is apparent that, on the average, it takes longer to close a claim with payment. In 1980–1984, the average time lapse between injury date and the closure date was 59 months for claims with an indemnity payment, yet it was only 52 months on claims without an indemnity payment. In 1985–1989, the average time lapse was 69 months on claims with an indemnity payment and 63 months on claims without an indemnity payment. In 1990–1994, the average time lapse for claims with an indemnity payment was 79 months, yet it was only 58 months on claims closed without an indemnity payment. In 1995–1999, the average time lapse for claims with an indemnity payment was 68 months but only 50 months on claims without an indemnity payment.

In looking at the different severities of injury for claims with an indemnity payment, the average length of time from the injury date to the closure date is longest for the claims with a grave permanent and a major permanent severity code. In general, claims with less significant severity codes have the shorter average time lapse from injury date to closure date. On average, across all severities and all years, it took between 25 and 30 months for a claim to be reported.

11. Average Indemnity of Paid Claims by Region

Claims with an indemnity payment are analyzed by region within the state. For purposes of this study, claims filed in Illinois are grouped into four different regions. Counties included in Region 1 are Cook, Madison, McHenry, St. Clair, and Will; counties included in Region 2 are DuPage, Kane, and Lake; and counties included in Region 3 are Champaign, Jackson, Macon, Sangamon, and Vermillion. The rest of the counties are grouped in the Other category.

Tables 11–1, grouped by closure date, list the number of claims with an indemnity payment, the percentage of total indemnity paid, and the average indemnity of a paid claim by region. For all the groupings, more than 50% of the total indemnity amount was paid in Region 1. For the groupings from 1985–1989 to 1995–1999, average indemnity payments were the highest in Region 1.

In each region, the average indemnity paid amount is increasing over the years, as shown in Graphs 11–1.

The distribution of claims by region by grouping is illustrated in Graphs 11–2 and appears to be consistent across all groupings.

Appendix A

NAIC MEDICAL PROFESSIONAL LIABILITY INSURANCE UNIFORM CLAIMS REPORT

Report each claim closed on or after July 1, 1976. Submit a report for each defendant insured by filing Insurer, including claims closed without payment. Complete all blocks on the form. If information is unknown, enter "UNK", if not applicable, enter "NA". When an item calls for a dollar amount and no amount is involved, enter 0 in the space after the \$ sign. When you prepare a report on a reopened case on which a previous report has been made, mark "Previously Reported" at the top of the report. Record all amounts in whole dollars only, all dates as MM YY and all ages (on date of occurrence) as YY.

1a. Name of insurer		1b. Claim file identification	
2a. Date of injury	2b. Date reported to insurer	2c. Date reopened	
3a. Insured's name	3b. Age	3c. City	3d. State 3e. Zip
4a. Profession or business (CODE)	4b. Specialty (CODE)	4c. Type of practice (Code)	
5a. Board certification (CODE)	5b. Foreign medical graduate?	5c. Country	
6a. Place where injury occurred (CODE)	6b. City	6c. State	6d. Zip
7a. Name of Institution (if injury occurred in institution)	7b. Location in institution (CODE)	7c. Hospital Identification(leave blank)	
8a. Injured person's name	8b. Age	8c. Sex	
9a. Total defendants involved in claim	9b. Derivative claim (CODE)		
10. Amount of reserve for indemnity if still outstanding \$	11. Amount of reserve for expenses if still outstanding \$		
12a. Plaintiff attorney's name	12b. City	12c. State	12d. Zip
13. Describe action which caused claim to be made			(Leave Blank)
			14a.
			14b.
14a. Final diagnosis for which treatment was sought or rendered (patient's actual condition)			15.
14b. Describe misdiagnosis made, if any, of patient's actual condition			15
15. Operation, diagnostic or treatment procedure causing the injury			16a
16a. Describe principal injury giving rise to the claim			16a
16b. Severity of injury (CODE)			
17a. Misadventures in procedures (CODE)		17b. Misadventures in diagnosis (CODE)	
18a. Others contributing to injury (CODE)	18b. Associated issues (CODE)	18c. Coverage (CODE)	
19. Companion claim file identification			
1.	2.	3.	4.
20a. Date of this payment or closure	20b. Claim disposition (CODE)	20c. Settlement (CODE)	
21a. Court (CODE)	21b. Binding arbitration (CODE)	21c. Review panel (CODE)	
22. Indemnity paid by you on behalf of this defendant		\$	
23. Other indemnity paid by you on behalf of this defendant		\$ D <input type="checkbox"/> E <input type="checkbox"/>	
24. Indemnity paid by all parties (for all defendants)		\$	
25. Loss adjustment expense paid to defense counsel		\$	
26. All other allocated loss adjustment expense paid by you		\$	
27. Injured person's incurred medical expense		\$	
28. Injured person's anticipated future medical expense		\$	
29. Injured person's incurred wage loss		\$	
30. Injured person's anticipated wage loss		\$	
31. Injured person's other expense		\$	
32. Total amount allocated for future periodic payments (for all defendants)		\$	

Contact Person and Telephone Number

Address

Person Responsible for Report
10/77

NAIC MEDICAL PROFESSIONAL LIABILITY INSURANCE UNIFORM CLAIMS REPORT INSTRUCTIONS

- 4a. Profession or Business Code: 1) physicians and surgeons, 2) hospitals, 3) other medical professionals, 4) other health care facilities. (When 3 is entered, specify type of professional in addition.)
- 4b. Specialty Code: (five digits) from ISO Common Statistical Base classifications.
- 4c. Type of Practice Code: 1) institutional (academic), 2) professional corporation or partnership (group), 3) self-employed, 4) employed physician, 5) employed nurse, 6) all other employees, 7) intern or resident.
- 5a. Enter appropriate code if insured physician is Board Certified in 1) specialty coded in 4b, 2) a different specialty, 3) both specialty coded in 4b and another specialty, 4) insured physician is not board-certified. If 2 or 3 is entered, also enter the additional specialty code (5 digits) in this line.
- 5b. Indicate yes or no if insured physician is a Foreign Medical Graduate.
- 5c. Enter Country in which primary medical education was received if other than U.S.
- 6a. Enter the appropriate code of the Place Where the principal Injury Occurred: 1) hospital inpatient facility, 2) emergency room, 3) hospital outpatient facility, 4) nursing home, 5) physician's office, 6) patient's home, 7) other outpatient facility, 8) other, 9) other hospital/institutional location. Use only one code. If code 8, other, is used enter description of the place.
- 7b. Enter appropriate code if Location of Institutional Injury was: 1) patient's room, 2) labor and delivery room, 3) operating suite, 4) recovery room, 5) critical care unit, 6) special procedure room, 7) nursery, 8) radiology, 9) physical therapy department.
- 9a. Enter the Total Number of Defendants (persons and institutions other than John Does) Involved in Claim
- 9b. Enter the appropriate code(s) if a Derivative Claim (on behalf of someone other than the medically injured) was made by: 1) spouse, 2) children, 3) parent, 4) personal representative.
- 14a. Use nomenclature and/or descriptions to enter the Final Diagnosis for which Treatment was Sought or Rendered (actual abnormal condition), and also 14b, the Misdiagnosis, if any, of the Patient's Actual Condition.
15. Use nomenclature and/or descriptions of the procedure used. Include method of anesthesia, or name of drug used for treatment, with detail of administration.
- 16a. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable.
- 16b. Enter one digit code for Severity of Injury from scale provided below. Enter the code for the most serious injury if several are involved.

Severity of Injury Scale Examples

	1) Emotional only	Fright, no physical damage
Temporary	2) Insignificant	Lacerations, contusions, minor scars, rash. No delay.
	3) Minor	Infections, misset fracture, fall in hospital. Recovery delayed.
	4) Major	Burns, surgical material left, drug side effect, brain damage. Recovery
Permanent	5) Minor	Loss of fingers, loss or damage to organs. Includes no disabling injuries.
	6) Significant	Deafness, loss of limb, loss of eye, loss of one kidney or lung.
	7) Major	Paraplegia, blindness, loss of two limbs, brain damage.
	8) Grave	Quadriplegia, severe brain damage, lifelong care or fatal prognosis.
	9) Death	

- 17a. Enter the appropriate Misadventure Code(s) if the Procedure was: 1) not adequately indicated, 2) contraindicated, 3) there was a more appropriate alternative, 4) delayed, 5) improperly performed, 6) not performed, 7) occasioned by misdiagnosis, 8) inadequate assessment, 9) mis-identification of the patient, 10) delay in notifying physician, 11) failure to notice an improper order, 12) failure to obtain a proper order, 13) failure to instruct patient.
- 17b. Enter the appropriate code if the following Misadventures in Diagnosis caused or aggravated the injury: 1) delay in diagnosis, 2) misdiagnosis of the abnormal condition, 3) misdiagnosis in the absence of an abnormal condition.
- 18a. Enter the appropriate code(s) if any Other person(s) caused or Contributed to the Injury: 1) attending physician, 2) house staff, 3) consultant, 4) nurse R.N., 5) nurse L.P.N. or L.V.N., 6) aide, 7) orderly, 8) pharmacist, 9) radiologist, 10) radiology technician, 11) anesthesiologist, 12) anesthetist, 13) pathologist, 14) laboratory technician, (15) physician's assistant, (16) O.R. technician, 17) physical therapist, 18) inhalation therapist, 19) other therapists, 20) other technicians, 21) dietitian, 22) maintenance personnel, 23) engineer, 24) administrator, 25) other personnel, 26) patient, 27) another patient.
- 18b. Enter the appropriate code(s) if one or more of the following factors were Associated Issues in the claim: 1) abandonment, 2) premature discharge from institution, 3) false imprisonment, 4) lack or delay of consultation, 5) lack of supervision, 6) breach of confidentiality, 7) failure to prevent an abnormal condition, 8) failure to accomplish intended result, 9) failure to conform with regulation or statutory rule, 10) lack of adequate facilities or equipment, 11) laboratory error, 12) pharmacy error, 13) products liability, 14) failure to timely disclose, 15) failure to provide warning instructions, 16) lack of consent from proper person, 17) inadequate information for informed consent, 18) procedure exceeded consensual understanding, 19) breach of contract, 20) warranty, 21) assault and battery, 22) res ipsa loquitur, 23) emergency equipment, 24) cooling devices, 25) heating devices, 26) cautery equipment, 27) x-ray equipment, 28) radiation therapy equipment, 29) traction equipment, 30) anesthesia equipment, 31) operative equipment, 32) surgical instruments and materials, 33) food preparation equipment, 34) laboratory equipment, 35) laboratory mislabeling, 36) laboratory computation error, 37) inadequate laboratory specimen, 38) lost laboratory specimen, 39) laboratory interpretation, 40) laboratory reporting error, 41) laboratory delay in reporting, 42) sterilization of equipment, 43) skin preparation, 44) aseptic technique, 45) isolation for infection control, 46) records, 47) billing and collection, 48) inter-professional relations, 49) vicarious liability, 50) statute of limitations, 51) punitive damages.
- 18c. Enter the appropriate Coverage Code for the type of policy covering the claim: 1) policy covers all claims made during the term of the policy, 2) policy covers all claims made during the policy term for events which occurred during a designated previous policy term, 3) policy covers all claims whenever presented for events which occur during the policy term.
- 20b. Enter final method of Claim Disposition: 1) settled by parties, 2) disposed of by a court, 3) disposed of by binding arbitration.
- 20c. If settled by agreement of parties, enter appropriate Settlement Code: 1) before filing suit or demanding hearing, 2) before trial or hearing, 3) during trial or hearing, 4) after trial or hearing, but before judgment or decision (award), 5) after judgment or decision, but before appeal, 6) during appeal, 7) after appeal, 8) claim or suit abandoned, 9) during review panel or non-binding arbitration.
- 21a. Enter the appropriate Court Code: 0) no court proceedings, 1) directed verdict for plaintiff, 2) directed verdict for defendant, 3) judgment notwithstanding the verdict for the plaintiff, 4) judgment notwithstanding the verdict for the defendant, 5) judgment for the plaintiff, 6) judgment for the defendant, 7) for plaintiff after appeal, 8) for defendant after appeal, 9) all other.
- 21b. Enter appropriate Binding Arbitration Code: 0) claim not subject to arbitration, 1) claim subject to arbitration, but previously coded disposition reached in lieu of award, 2) award for plaintiff, 3) award for defendant.
- 21c. If a review panel or non-binding arbitration was used in disposition, enter appropriate code: 1) finding for plaintiff, 2) finding for defendant.
23. Mark appropriate box if this amount was a deductible paid by the insured or indemnity paid under an excess limits policy by another insurer.
25. Enter fees paid to your defense counsel for this defendant.
26. Enter filing fees, telephone charges, photocopy fees, expenses of defense counsel, etc.
28. Enter best estimate of future medical expense if it appears the claimant will incur expenses in the future.
30. Enter best estimate of future wage loss if it appears the claimant will incur wage loss in the future.
32. If a reserve, annuity, trust fund or similar mechanism was established to provide future periodic payments, enter total amount thereof.

Appendix B

Definitions of the types of practices/specialties, that may need clarification:

Anesthesiology—the branch of medicine specializing in the pharmacological depression of nerve function

Cardiac—pertaining to the heart and the esophageal opening of the stomach

Cardiovascular—relating to the heart and the blood vessels or the circulation

Internal Medicine—the branch of medicine concerned with nonsurgical diseases in adults, but not including diseases limited to the skin or to the nervous system

Neurosurgery—specializing in the surgery of the brain and nervous system

OB/GYN Surgery—surgery for the female genital tract; surgery for women during pregnancy and childbirth

Ophthalmology—the study of the eye and its diseases

Orthopedic—the branch of medicine dealing with the surgery of bones and joints

Otorhinolaryngology—the study of the combined specialties of diseases of the ear, nose and larynx

Pediatrics—the medical specialty concerned with the study and treatment of children

Radiology—the branch of medicine using radiant energy, such as x-rays, in the diagnosis and treatment of disease

Thoracic Surgery—surgery of the chest

Vascular Surgery—surgery pertaining to blood vessels

Urology—the medical specialty concerned with the study, diagnosis and treatment of diseases of the urinary tract

Sources:

Home Medical Dictionary, P.S.I & Associates, Inc., 1988 Ottenheimer Publishers, Inc.

Stedman's Medical Dictionary, William R. Hensyl, 1990 Williams & Wilkins



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